

REPORT



November 2015

# The Uninsured: A Primer

KEY FACTS ABOUT HEALTH INSURANCE AND  
THE UNINSURED IN THE ERA OF HEALTH REFORM

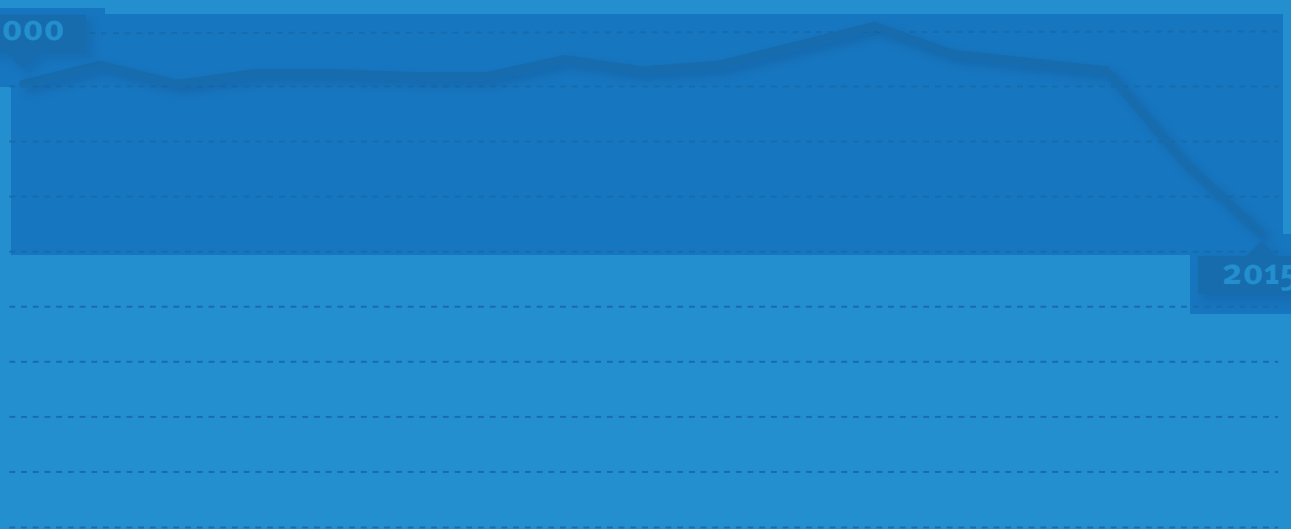
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# Table of Contents

- Introduction..... 1
- What was happening to insurance coverage leading up to the ACA?..... 2
  - Employer-Sponsored Health Insurance Coverage..... 2
  - Non-Group Health Insurance Coverage ..... 2
  - Public Health Insurance Coverage..... 3
  - The Uninsured..... 3
- How did health coverage change under the ACA?..... 5
  - The Uninsured..... 5
  - Medicaid Expansion..... 6
  - Health Insurance Marketplaces and Non-Group Coverage.....7
  - Employer Sponsored Insurance Under the ACA ..... 8
- Who remains uninsured after the ACA and why do they lack coverage? .....10
- How does lack of insurance affect access to health care?.....12
- What are the financial implications of lacking insurance?.....14
- Conclusion .....16
- Endnotes ..... 17

# Introduction

Millions of people in the United States go without health insurance each year. Because nearly all of the elderly are insured by Medicare, most uninsured Americans are nonelderly (under age 65). A majority of the nonelderly receive their health insurance as a job benefit, but not everyone has access to or can afford this type of coverage. The Affordable Care Act (ACA), which was passed in 2010, aimed to expand coverage by providing for an expansion of Medicaid for adults with incomes at or below 138% of poverty, building on employer-based coverage, and providing premium tax credits to make private insurance more affordable for many with incomes between 100-400% of poverty.<sup>1</sup> Most of the major coverage provisions of the ACA went into effect in 2014, and millions of people have gained coverage under the law. However, many continue to lack coverage for a variety of reasons. For example, Medicaid eligibility for adults remains limited in states that have not adopted the expansion, some people remain ineligible for financial assistance for private coverage, and some still find coverage unaffordable even with financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's access to needed medical care and their financial security. The access barriers facing uninsured people mean they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact also can be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

*The Uninsured: A Primer* provides information on how insurance changed under the ACA, how many people remain uninsured, who they are, and why they lack health coverage. It also summarizes what we know about the impact lack of insurance can have on health outcomes and personal finances and the difference health insurance makes in people's lives.

# What was happening to insurance coverage leading up to the ACA?

The coverage provisions in the ACA built on and attempted to fill in the gaps in a piecemeal insurance system that left many without affordable coverage. Historically, most people in the United States obtained health insurance coverage as a fringe benefit through a job. However, many people were left out of the employer-based system, and the availability of employer-based coverage has eroded over time. Some people purchased coverage on their own, but this type of coverage could be costly or difficult to obtain. While Medicaid and the Children's Health Insurance Program (CHIP) had expanded over time to cover more low-income individuals (primarily children) and have been an important source of coverage during economic downturns, many poor parents and most poor adults without dependent children remained ineligible. As a result of these gaps in our public and private health insurance systems, the number of uninsured people increased over time, leaving over 41 million nonelderly people in the country without health coverage in 2013.<sup>2</sup>

## EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE

**Historically, the majority of employers offered group health insurance policies to their employees and to their employees' families, but not all workers had access to or could afford such coverage.** In 2013, 57% of firms offered employee coverage.<sup>3</sup> Cost was the most common reason employers cited for not offering health coverage,<sup>4</sup> and many low- and moderate-income workers who were offered employer coverage found their share of the premium unaffordable, especially if they needed more expensive family coverage.<sup>5</sup> Workers in low-wage firms and those in small firms were less likely than other workers to be offered coverage.<sup>6</sup>

**The availability of employer-sponsored coverage and the share of the population with this type of coverage had declined over time.** From 1999 to 2013, the share of firms that offered benefits to their workers declined from 66% to 57%, primarily due to fewer small firms offering coverage.<sup>7</sup> Also during this period, health insurance premiums, as well as the employee's share of those premiums, nearly doubled, outpacing growth in workers' earnings and overall inflation, and take-up rates among eligible workers declined slightly.<sup>8</sup> The share of the nonelderly population with employer-sponsored coverage declined between 2000 and 2007,<sup>9</sup> even during years when the economy was strong and growth in health insurance premiums was slowing. The Great Recession caused an even steeper drop in employer coverage from 2008 to 2010 due to widespread unemployment. While the decline in employer coverage slowed from 2010 to 2013 as the economy began to stabilize, rates of employer coverage remained below pre-recession levels.<sup>10</sup>

## NON-GROUP HEALTH INSURANCE COVERAGE

**Very few people were covered by non-group health insurance policies prior to the ACA.** Private policies directly purchased in the non-group, or individual, market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.<sup>11</sup> Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Nationwide, the average monthly premium per person in the non-group market in 2013 was \$236, with substantial variation by state,<sup>12</sup> and deductibles and other cost sharing in non-group plans were often higher than in employer-sponsored coverage. Further, premiums in the non-group market could vary by age or health status, and people with health problems or at

risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether. In 2013, 41% of adults who previously tried to purchase non-group insurance said that the policy offered to them was too expensive, and nearly 6% said that no insurance company would sell them a policy at any price.<sup>13</sup> Those who were in fair or poor health were twice as likely to be denied.<sup>14</sup>

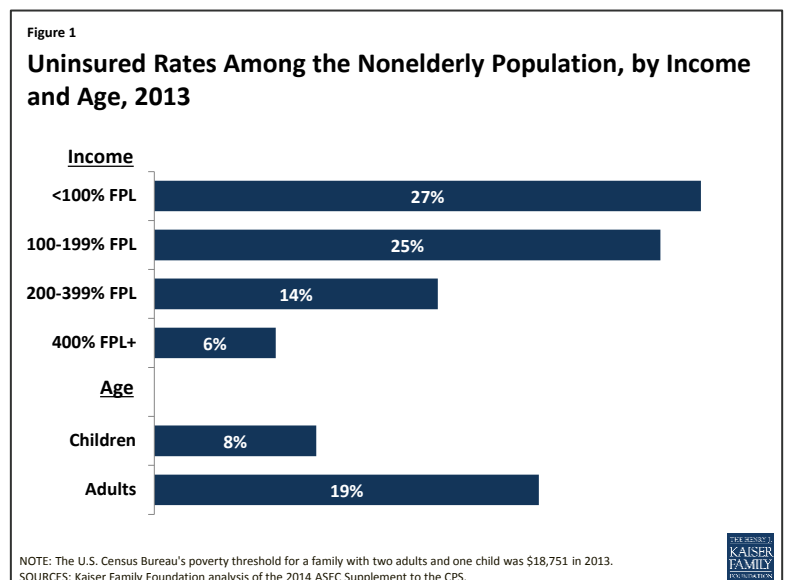
## PUBLIC HEALTH INSURANCE COVERAGE

**Medicaid and CHIP have always been important sources of coverage for low-income children and people with disabilities, but in the past, coverage for adults without disabilities was limited.** In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population<sup>15</sup> by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities. Even before the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for infants and preschool children), and states had expanded coverage for children in families with higher incomes through CHIP. In contrast, the role of Medicaid for nonelderly adults was more limited. While some states covered adults at higher income levels, state Medicaid programs were only required to cover parents up to states' 1996 welfare eligibility levels (often below 50% of the federal poverty level), and in most states, adults without dependent children—regardless of how poor—were ineligible for Medicaid. Differences in eligibility manifested in divergent coverage rates for low-income children and adults: In 2013, over three-quarters (77%) of poor children and nearly two-thirds (65%) of near-poor children (under 200% of the federal poverty level) were covered by Medicaid or CHIP, while only 35% of poor and 27% of near-poor nonelderly adults were covered by these programs.<sup>16</sup>

## THE UNINSURED

**The historical gaps in the insurance system left many without an affordable source of coverage.** In 2013, 41.3 million nonelderly people in the U.S. lacked health insurance.<sup>17</sup> The main reason that most people said they lacked coverage was inability to afford the cost.<sup>18</sup>

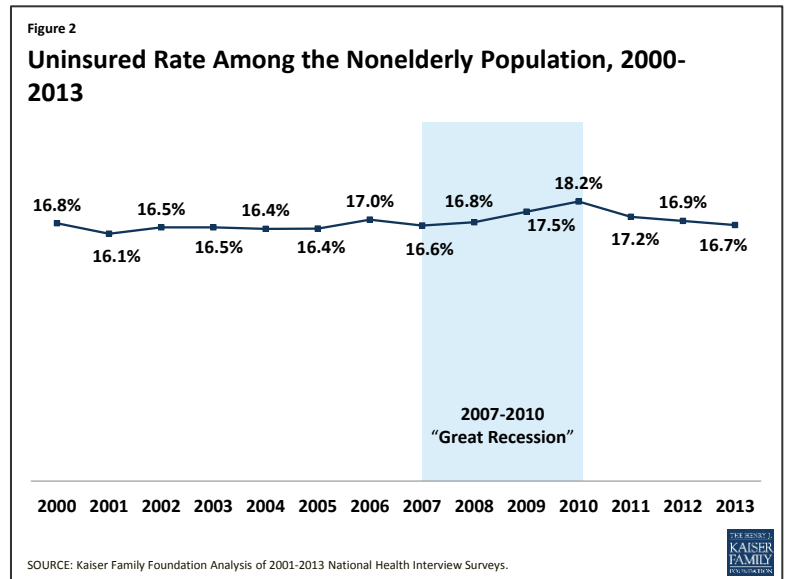
**Some groups were at higher risk of being uninsured than others, largely reflecting limited availability of affordable coverage for some populations.** Individuals with incomes below poverty or between 100 and 200% of poverty had higher uninsured rates (27 and 25 percent, respectively, in 2013) than those with higher incomes (Figure 1).<sup>19</sup> (The poverty level for a family of two adults and one child was \$18,751 in 2013.<sup>20</sup>) In addition, reflecting historical exclusions in public coverage, adults were more likely than children to be uninsured (19% vs. 8% in 2013, Figure 1). People of color were more likely than Whites to be uninsured, as people of color are more likely to be low-income than Whites,<sup>21</sup> and non-citizens (legal and undocumented) were about three times more likely to be uninsured than citizens due to lower incomes and limited access to employer or public coverage.<sup>22</sup>



**Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs.** Insurance market regulations and the availability of jobs with employer-sponsored coverage also influenced the insurance rate in each state.<sup>23</sup> Massachusetts had the lowest uninsured rate in the country in 2013 (4%), due in part to health reform legislation enacted in 2006, while four states (Nevada, Texas, Arizona and Florida) had uninsured rates above 20%.<sup>24</sup>

**The uninsured rate increased leading up to the enactment of the ACA in 2010, particularly during the Great Recession.** The recent recession led to a steep increase in uninsured rates from 2008 to 2010 as many people lost their jobs and their access to employer-sponsored coverage.<sup>25</sup>

Medicaid and CHIP prevented steeper drops in insurance coverage, as many Americans became newly eligible for these programs when their income declined. From 2011 to 2013, uninsured rates dropped slightly as the economy improved and early provisions expanding coverage under the ACA went into effect. In 2013, the uninsured rate among nonelderly individuals was nearly 17%, a level comparable to pre-recession uninsured rates (Figure 2). Still, many uninsured individuals had been without coverage for long periods, often five years or more,<sup>26</sup> indicating that their lack of coverage was related to forces outside the recession.



# How did health coverage change under the ACA?

In January 2014, the major coverage provisions of the ACA went into effect, including the expansion of Medicaid and creation of Health Insurance Marketplaces with premium subsidies. The ACA also builds on employer-based coverage and introduced new requirements for almost all individuals to obtain insurance coverage or pay a penalty. Under the ACA, millions of people have gained insurance coverage, and the number and rate of uninsured has declined significantly.

## THE UNINSURED

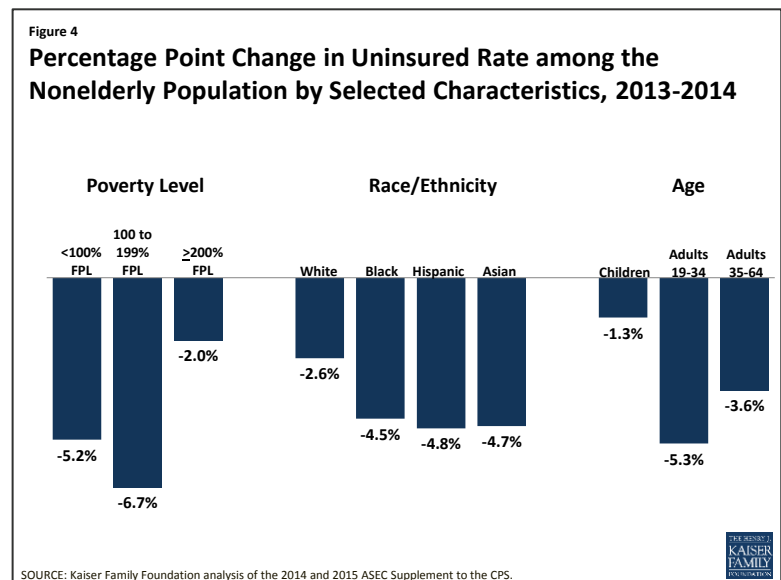
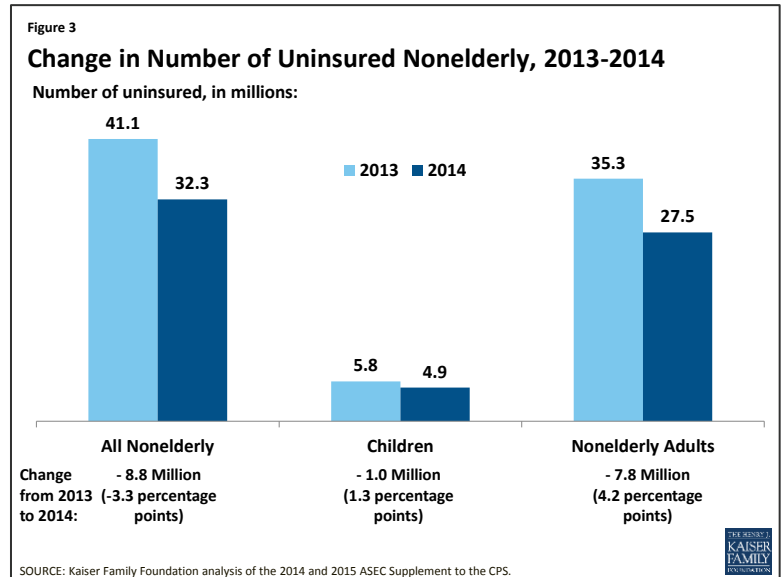
### The number of uninsured Americans declined significantly in 2014.

Corresponding with implementation of the ACA coverage provisions, the total number of nonelderly uninsured individuals nationally dropped from 41.1 million in 2013 to 32.3 million in 2014.<sup>27</sup> Nearly the entire decline in the number of uninsured people occurred among adults (Figure 3).

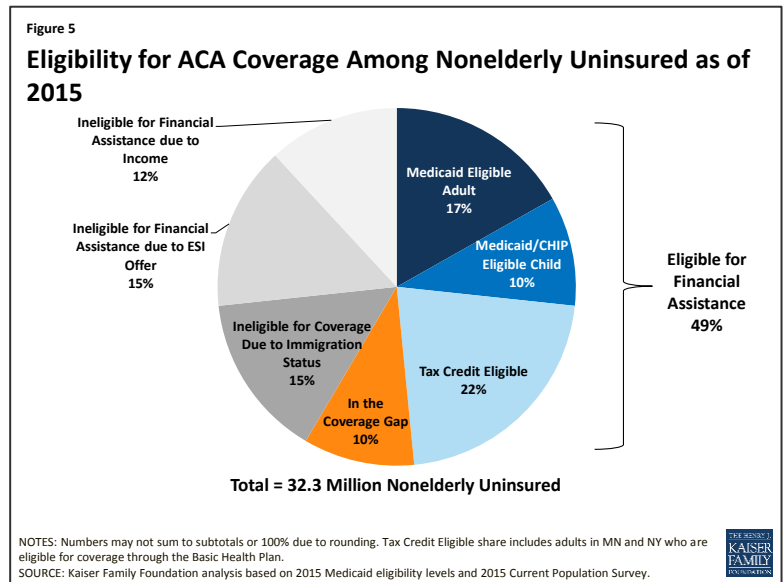
### Coverage gains were largest among low-income people, people of color, and young adults groups that had high uninsured rates prior to 2014.

While uninsured rates decreased across all income groups from 2013 to 2014, they declined most sharply for poor and near-poor people, dropping by 5.2 percentage points and 6.7 percentage points, respectively. Also over this period, the uninsured rate declined by 5.3 percentage points for adults age 19-34. Among racial and ethnic groups, Hispanics, Blacks, and Asian Americans had particularly large declines in uninsured rates, with each group seeing a drop of approximately 5 percentage points from 2013 to 2014 (Figure 4).<sup>28</sup>

**Growth in Medicaid and directly-purchased coverage accounted for much of the decline in the uninsured rate.** While the ACA was leading to major changes in health insurance coverage in 2014, these changes were occurring against the backdrop of the normal cycles of health coverage that people experience as their employment and income circumstances change. Therefore, though a plurality of nonelderly adults who gained coverage in 2014 did so through Medicaid (36%) or the Marketplace (22%), many people also gained other coverage, such as employer coverage (26%).<sup>29</sup> In addition, some people who were insured before 2014 also enrolled in ACA coverage options. For example, some of the people who were purchasing coverage on their own instead purchased that coverage through the new Marketplaces, and some people who lost coverage and were low-income took up Medicaid.<sup>30</sup>

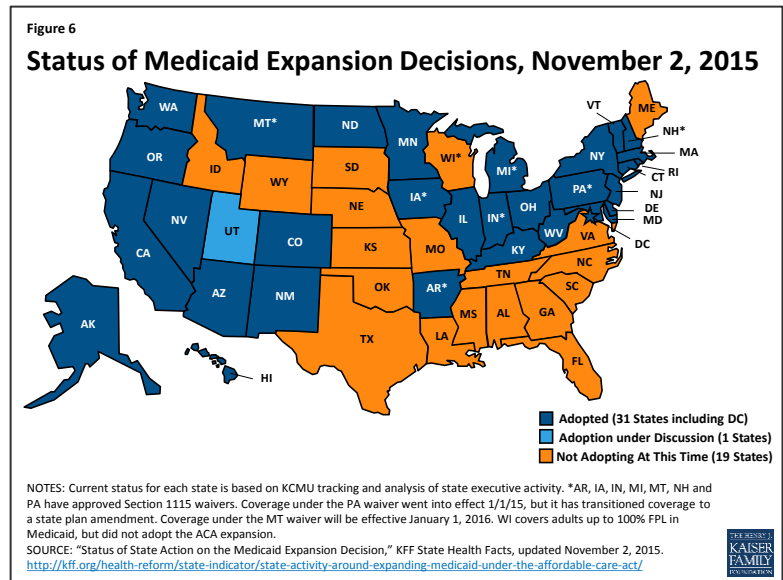


**Even with the ACA, many remain uninsured.** Of those who remained uninsured at the start of 2015, about half (15.7 million, or 49%) are eligible for financial assistance through either Medicaid or subsidized Marketplace coverage (Figure 5). However, many uninsured people remain outside the reach of the ACA. Some (4.9 million, or 15%) are ineligible due to their immigration status, and others (3.1 million, or 10%) are ineligible due to their state’s decision not to expand Medicaid. The remainder of the uninsured either has an offer of coverage through an employer or has income above the limit for Marketplace tax credits. These patterns of eligibility vary by state.<sup>31</sup>



## MEDICAID EXPANSION

**The ACA expanded Medicaid eligibility to adults with incomes at or below 138% of poverty, but the 2012 Supreme Court ruling effectively made the expansion a state option.** As of November 2015, 30 states and DC had adopted the Medicaid expansion (Figure 6).<sup>32</sup> Among states that have implemented the expansion, median income eligibility levels for parents rose from 98% FPL before the ACA to 138% FPL, while the median income eligibility level for childless adults increased from 0% to 138% FPL.<sup>33</sup> There is no deadline for states to expand Medicaid, and discussion about the Medicaid expansion continues in other states.<sup>34</sup>



**Medicaid and CHIP also remain an important source of coverage for children, pregnant women, and people with disabilities.** As of January 2015, all but two states cover children at or above 200% FPL through Medicaid and CHIP, with 19 states covering children at or above 300% FPL. Many (33) states cover pregnant women at or above 200% FPL.<sup>35</sup> In addition, Medicaid covers many individuals with disabilities, who are generally eligible for Medicaid based on enrollment in the Supplemental Security Income (SSI) program. Under the ACA, people with disabilities who live in expansion states also may qualify for Medicaid based solely on their low-income status.<sup>36</sup>

**In the twenty states that had not expanded Medicaid as of fall 2015, over three million poor adults fall into a “coverage gap.”<sup>37</sup>** These adults have incomes above Medicaid eligibility limits in their



state but below the lower limit for Marketplace premium tax credits, which begin at 100% FPL. In non-expansion states, the median income eligibility level for parents is 44% FPL and 0% for childless adults. People in the coverage gap are concentrated in Southern states, with the largest number of people in the coverage gap in Texas (766,000 people) followed by Florida (567,000), Georgia (305,000), and North Carolina (244,000). State decisions about expanding coverage have implications for coverage gains: among people below poverty, Medicaid expansion states had a 9.3 percentage point drop in adult uninsured rates, versus a 4.8 point drop in non-expansion states.<sup>38</sup>

**Undocumented immigrants and many recent lawfully present immigrants remain ineligible for Medicaid under the ACA.** Many uninsured non-citizens are in the income range to qualify for the ACA Medicaid expansion. However, under federal rules, undocumented immigrants may not enroll in Medicaid. Many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll, and some groups of lawfully present immigrants remain ineligible regardless of their length of time in the country.<sup>39</sup>

**Medicaid enrollment has grown under the ACA.** As of August 2015, national enrollment in Medicaid and CHIP had grown by over 14.5 million people since the period before open enrollment (which began October 2013), covering over 72 million people. This growth represents an increase of 24% in monthly Medicaid enrollment.<sup>40</sup> In states that had adopted the Medicaid expansion, enrollment increased by roughly 30% since the period before open enrollment, compared to an average increase of 10% in states that had not.<sup>41</sup>

**States have implemented modernized and streamlined enrollment processes under the ACA, but work continues in many areas.** To implement these processes, states made major upgrades to or built new Medicaid eligibility and enrollment systems, with the federal government providing enhanced funding for these efforts.<sup>42</sup> As of January 2015, individuals could apply online for Medicaid in all but one state, and 47 states accept Medicaid applications by phone. In addition, states established eligibility verification policies that rely on electronic data and minimize paperwork for individuals. However, efforts to implement the ACA's vision of a modernized, streamlined enrollment system continue in many areas, including implementing streamlined renewal processes and enhancing and expanding system functionalities.<sup>43</sup>

## HEALTH INSURANCE MARKETPLACES AND NON-GROUP COVERAGE

**The ACA established Health Insurance Marketplaces where individuals and small employers can purchase insurance.** Health Insurance Marketplaces are established in each state, but only some states run their own Marketplace.<sup>44</sup> These Marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans. To help ensure that coverage purchased in these new Marketplaces is affordable, the federal government provides tax credits for people with incomes between 100% FPL (\$20,090 for a family of three in 2015) and 400% FPL (\$80,360 for a family of three in 2015).<sup>45,46</sup> These tax credits limit the cost of the premium to a share of income and are offered on a sliding scale basis. In addition to the premium tax credits, the federal government also makes available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty have to pay out-of-pocket to access health services. The cost-sharing subsidies are also available on a sliding scale based on income.

**Millions of people have received financial assistance to purchase insurance through the Marketplaces.** As of June 30, 2015, nearly 10 million individuals were enrolled in a Marketplace plan.<sup>47</sup> The vast majority of Marketplace enrollees (84%) received premium subsidies, averaging \$270 per person, and 56% additionally received cost-sharing subsidies.<sup>48</sup> For a 40 year old non-smoker, the median price for the second-lowest cost Silver plan in 2015 is \$258,<sup>49</sup> with significant variation both across and within states. If this individual were earning \$30,000, he or she would pay \$208 after tax credits.<sup>50</sup> Still, affordability remains a concern for people with Marketplace coverage. A third (33%) of people with Marketplace coverage said they found it difficult to pay their monthly premium, and 28% said they faced higher than expected costs under their plan.<sup>51</sup> Affordability is a particular concern for people enrolled in Bronze plans, which carry high cost sharing. In 2015, the average annual deductible in a Bronze plan was \$5,331,<sup>52</sup> and plans could also impose additional co-pays. During the first two years of ACA coverage, 20% of Marketplace enrollees were enrolled in a Bronze Plan.<sup>53</sup>

**Lawfully present immigrants may receive tax credits for Marketplace coverage; however, undocumented immigrants are prohibited from purchasing such coverage.** Lawfully present immigrants are eligible for tax credits for coverage purchased through a Marketplace, regardless of the number of years they have been in the U.S.<sup>54</sup> In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for Marketplace coverage. Undocumented immigrants are not eligible for premium tax credits and are prohibited from purchasing insurance in the Marketplace at full cost.

**Some people continue to purchase non-group coverage outside the Marketplace.** Among the entire non-group market in winter 2015, over half of individuals (59%) reported having coverage obtained from a state or federal Marketplace, 17% have ACA-compliant coverage purchased outside of the Marketplace, and 16% have non-ACA-compliant plans (those that have been in effect since before January 1, 2014).<sup>55</sup> People purchasing coverage outside the Marketplace are not eligible for ACA premium tax credits.

## EMPLOYER SPONSORED INSURANCE UNDER THE ACA

**The ACA includes provisions to promote coverage in small firms.** Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA established the Small Business Health Options Program (SHOP) Marketplace, where employers with no more than 50 full-time equivalent (FTE) employees can purchase coverage. Beginning in January 2016, states have the option to expand the SHOP to include employers with 100 or fewer FTEs.<sup>56</sup> Small employers with no more than 25 FTEs employees and annual wages of less than \$50,000 that purchase coverage through the SHOP may be eligible for tax credits to reduce the cost of that coverage.<sup>57</sup> Eligible employers may take the tax credits for a maximum of two years.<sup>58</sup>

**The ACA also extends dependent coverage.** As of 2010, young adults may remain on their parents' private plans (including non-group plans or employer-based plans) until age 26. This provision expanded coverage among young adults.<sup>59</sup>

**Large employers now face penalties for not providing affordable coverage to full-time employees.** As of 2015, employers with 100 or more employees are assessed a fee up to \$2,000 per full-time

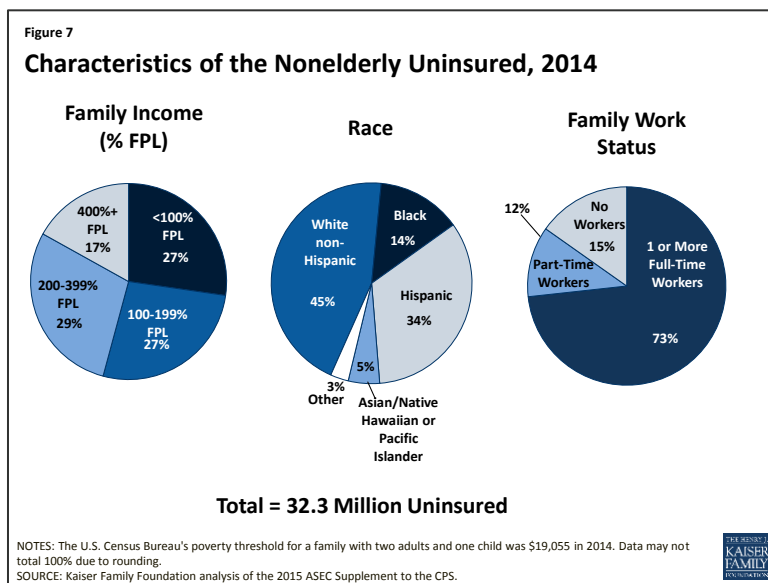
employee (in excess of 30 employees) if they do not offer affordable coverage and have at least one employee who receives a premium tax credit through a Marketplace.<sup>60</sup> These penalties will go into effect in 2016 for employers with 50-100 workers. To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee share of the individual premium must not exceed 9.5% of family income. This requirement does not apply to employers with fewer than 50 workers.<sup>61</sup> While the employer requirements may help many uninsured individuals with a worker in their family, the vast majority (81%) of uninsured workers in 2014 worked in firms with fewer than 50 employees, which are not required to provide insurance coverage.<sup>62</sup>

**Offer, eligibility, and take-up rates of employer sponsored insurance have remained unchanged since 2013.** Over half (57%) of firms offer health benefits to their employees in 2015, a rate that is unchanged from the offer rates in 2014 (55%) and 2013 (57%). Similarly, the percentage of workers eligible for health benefits at offering firms in 2015 (79%) is similar to 2014 (77%) and 2013 (77%), and take-up rates have also remained steady, with 79% of eligible workers taking up offered coverage in 2015, compared with 80% in 2014 and 2013.<sup>63,64,65</sup>

# Who remains uninsured after the ACA and why do they lack coverage?

Even after the ACA, 32 million nonelderly people in the United States are uninsured as of the end of 2014. Despite coverage gains, groups with historically high uninsured rates continue to be at highest risk of being uninsured, including low-income individuals, adults, and people of color. Cost continues to pose a major barrier to coverage with nearly half (48%) of the uninsured in 2014 saying that the main reason they lacked coverage was because it was too expensive.<sup>66</sup>

**Though provisions in the ACA aim to make coverage more affordable for low and moderate-income families, these income groups still make up the vast majority of the uninsured (Figure 7).** More than half of the remaining uninsured population (54%) has family income at or below 200% FPL (\$19,055 for a family of three in 2014)<sup>67</sup> and another 29% has family income between 200 and 399% FPL. Low-income individuals are at the highest risk of being uninsured.<sup>68</sup> As discussed below, the cost of coverage remains a barrier to insurance for many.



**Racial/ethnic minorities are at higher risk of being uninsured than Whites.** While a plurality (45%) of the uninsured are non-Hispanic Whites, people of color are disproportionately likely to be uninsured: they make up less than 40% of the overall U.S. population but account for over half of the total uninsured population (Figure 7). Hispanics and non-Hispanic Blacks have higher uninsured rates (21% and 13%, respectively) than Whites (9%).<sup>69</sup> Differences in coverage by race/ethnicity likely reflect a combination of factors, including language and immigration barriers, income and work status, and state of residence.

**A majority of the remaining uninsured population is in a family with at least one worker, and many uninsured workers continue to lack access to coverage through their job.** As of the end of 2014, over seven in ten (73%) of the uninsured have at least one full time worker in their family, and an additional 12% have a part-time worker in their family (Figure 7).<sup>70</sup> As in the past, low-income workers and those who work in blue-collar jobs (versus white-collar jobs) are more likely than other workers to be uninsured.<sup>71</sup> Uninsured adults report that access to coverage through a job remains limited or unaffordable.<sup>72</sup>

**Adults are still more likely than children to be uninsured.** Nonelderly adults were more than twice as likely as children (14% vs. 6%) to be uninsured in 2014.<sup>73</sup> This disparity reflects ongoing differences in eligibility for public coverage. While the ACA has increased Medicaid eligibility levels for adults, they remain below those of children in most states, and adults without children are excluded from Medicaid in all but one non-expansion state.<sup>74</sup>

**Uninsured rates for children are low, and most uninsured children are eligible for either Medicaid/CHIP or Marketplace coverage.** Largely due to expanded eligibility for public coverage under Medicaid and CHIP, the uninsured rate for children is relatively low: in 2014, 6% of children nationwide were

uninsured, and five states (Maryland, Louisiana, West Virginia, Connecticut, and Rhode Island) have children's uninsured rates below 3%.<sup>75</sup> Nearly two-thirds (65%) of uninsured children are eligible for Medicaid or CHIP.<sup>76</sup> Some of these children may be reached by covering their parents, as research has found that parent coverage in public programs is associated with higher enrollment of eligible children.<sup>77</sup>

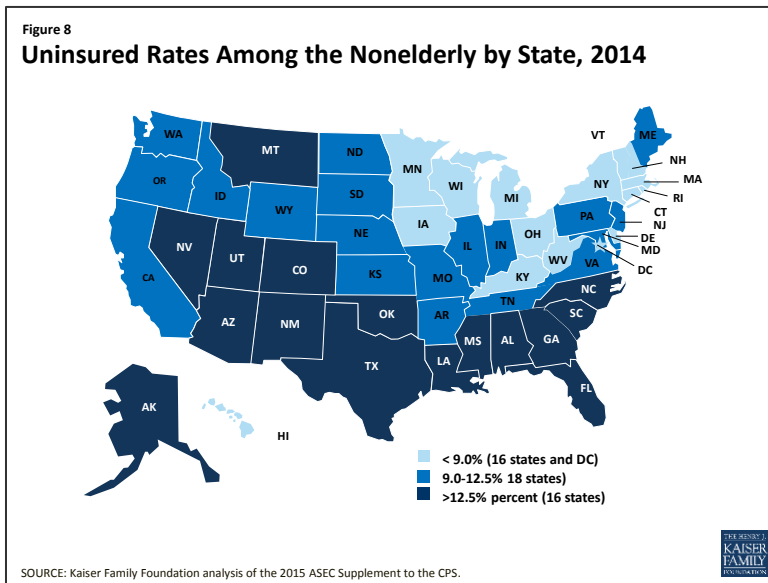
**Insurance coverage continues to vary by state and region, with individuals living in the South and West the most likely to be uninsured (Figure 8).** In 2014, the ten states with the highest uninsured rates were all in the South and West,<sup>78</sup> reflecting state Medicaid expansion status, demographic characteristics, economic conditions, availability of employer-based coverage, and state outreach efforts under the ACA.

**While most of the uninsured are U.S. citizens, non-citizens continue to be at much higher risk of being uninsured. In**

2014, nearly three out of four (73%) uninsured nonelderly individuals were U.S. citizens. However, non-U.S. citizens are more likely than native U.S. citizens to be uninsured in 2014. Among native U.S. citizens, 10% were uninsured in 2014, compared to 28% of non-citizens who have lived in the U.S. for fewer than five years and 34% who have lived in the U.S. for more than five years.<sup>79</sup> Some non-citizens are ineligible for coverage under the ACA due to their immigration status.

**Cost still poses a major barrier to coverage for the uninsured.** In 2014, 48% of uninsured adults said that the main reason they lacked coverage was because it was too expensive. Eligibility is also a barrier: 12% of uninsured adults mentioned work-related reasons, such as being unemployed or not having an offer through work, and 14% said they were told they were ineligible or could not get coverage due to their immigration status. Few uninsured adults said they were uninsured because they do not need coverage, oppose the ACA, or would rather pay the penalty.<sup>80</sup>

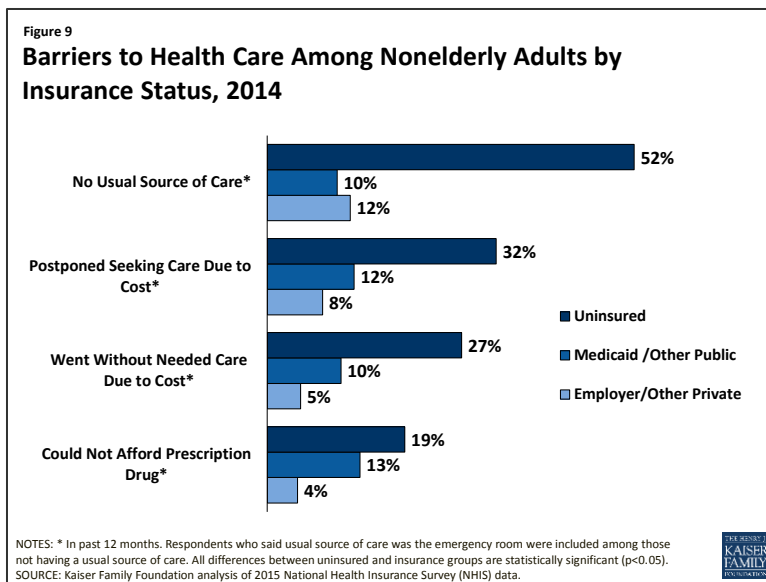
**Most people who remained uninsured in 2014 had been without coverage for long periods of time.** Among adults who remained uninsured at the end of 2014, 29% reported that they had been uninsured for one to five years, 24% reported they had been uninsured for more than five years, and 18% reported that they had never had coverage.<sup>81</sup> People who have been without coverage for long periods may be particularly hard to reach through outreach and enrollment efforts.



## How does lack of insurance affect access to health care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

**Uninsured people are far more likely than those with insurance to report problems getting needed medical care.** Over a quarter (27%) of adults without coverage say that they went without care in the past year because of cost compared to 5% of adults with private coverage and 10% of adults with public coverage. Part of the reason for poor access among the uninsured is that most (52%) do not have a regular place to go when they are sick or need medical advice (Figure 9).<sup>82</sup>

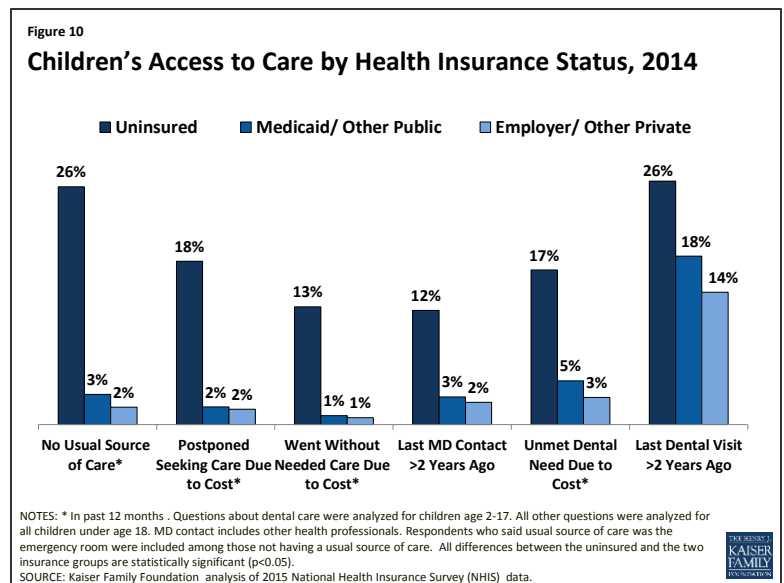


**Uninsured people are less likely than those with coverage to receive timely preventive care.** Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. In 2014, about a quarter (26%) of uninsured adults reported a preventive visit with a physician in the last year, compared to 67% of adults with employer coverage and 65% of adults with Medicaid.<sup>83</sup> Uninsured patients are also less likely than those with insurance to receive necessary follow-up screenings after abnormal cancer tests.<sup>84</sup> Consequently, uninsured individuals have an increased risk of being diagnosed at later stages of diseases, including cancer, and have higher mortality rates than those with insurance.<sup>85,86,87</sup>

**Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them.** In 2013, 14% of uninsured adults said they did not take a medication as prescribed, and 9% used alternative therapies in the past year to save money, compared to 6% and 4%, respectively, of those with private coverage.<sup>88</sup> And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.<sup>89</sup>

**Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.** When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.<sup>90,91,92,93</sup>

**Uninsured children also face problems getting needed care.** Uninsured children are more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 10).<sup>94</sup> Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others and are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.<sup>95</sup> Among children with special needs, those without health insurance have worse access to care, including specialist care, than those with insurance.<sup>96</sup>



**Lack of health coverage, even for short periods of time, results in decreased access to care.** Research has shown that adults who experience gaps in their health insurance coverage are less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.<sup>97</sup> Similarly, research indicates that children who are uninsured for part of the year have more access problems than those with full-year coverage.<sup>98</sup> Similarly, children who lack insurance for an entire year have poorer access to coverage than those who have coverage for at least part of the year, suggesting that even short periods of coverage improves access to care.<sup>99</sup>

**Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured.** A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.<sup>100</sup> Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35%, increased the likelihood of prescription drug utilization by 15%, and decreased the likelihood of depression and stress. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.<sup>101</sup> A separate study of Medicaid expansions for adults in three other states (New York, Maine, and Arizona) found that coverage gains were associated with reduced mortality, improvements in access to care, and better self-reported health status.<sup>102</sup>

**Public hospitals, community clinics and health centers, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured.** Safety net providers, including public and community hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.<sup>103,104</sup> Though the ACA made a large investment in community health centers to help meet the increasing demand for primary care as coverage expands,<sup>105</sup> and although health centers may see increased revenue as previously uninsured people gain Medicaid,<sup>106</sup> health center resources continue to be strained, especially in states not expanding Medicaid.

## What are the financial implications of lacking insurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs, like housing, food, and transportation to work, and many uninsured adults report difficulty paying basic monthly expenses such as rent, food, and utilities.<sup>107</sup> When uninsured people use health care, they may be charged for the full cost of that care and often face difficulty paying medical bills. Providers absorb some of the cost of care for the uninsured, but funding does not fully offset the cost of their care.

**Most uninsured people do not receive health services for free or at reduced charge.** Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.<sup>108,109</sup> In 2014, only 40% of uninsured adults who received health care services reported receiving free or reduced cost care.<sup>110</sup>

**Uninsured people often must pay "up front" before services will be rendered.** When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or be turned away.<sup>111</sup> Among uninsured adults who received health care in 2013, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.<sup>112</sup>

**People without health insurance spend half of what those with insurance spend on health care, but they pay a much larger portion of their medical costs out-of-pocket.** Compared to insured nonelderly people with full-year coverage, whose average per capita medical expenditures were \$4,876 in 2013, nonelderly people who were full-year uninsured used health care services valued at about half that amount, or just \$2,443 per capita in 2013. Despite lower overall medical spending, people without insurance pay nearly as much out-of-pocket as insured people.<sup>113</sup> In the aggregate, the uninsured pay for almost one-third (30%) of their care out-of-pocket, totaling \$25.8 billion in 2013. This total included costs for both full-year uninsured and the costs incurred during the months the part-year uninsured had no health coverage.<sup>114</sup>

**The uncompensated costs of care for the uninsured amounted to about \$84.9 billion in 2013.** Funding from a number of sources, totaling \$53.3 billion in 2013, helps providers defray the costs associated with uncompensated care. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided \$19.8 billion, and the private sector provided \$0.7 billion. While substantial, these payments to providers for uncompensated care amount to a small slice of total health care spending in the U.S.<sup>115</sup>

**The burden of uncompensated care varies across providers.** Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost of hospital-based care, the majority (60%) of uncompensated care is provided by hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of uncompensated care, and the remainder of uncompensated care, 14%, is provided by office-based physicians.<sup>116</sup> With the expansion of coverage under the ACA, providers are seeing reductions in uncompensated care costs, particularly in states that expanded Medicaid. For example, in one health system, hospitals in expansion states had large decreases in uninsured/self-pay volume and increases in Medicaid volume between 2013 and 2014, while hospitals in

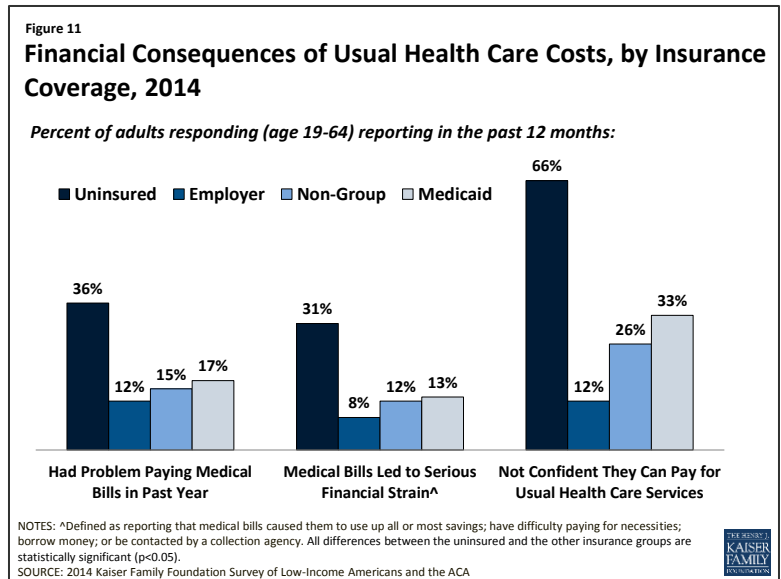


non-expansion states did not. Hospitals in expansion states saw a correspondingly larger drop in charity care costs (-40%) compared those in non-expansion states (-6%).<sup>117</sup>

**Safety net hospitals that serve a large number of uninsured individuals will receive a reduction in federal disproportionate share (DSH) Medicaid payments beginning in FY 2018.**<sup>118</sup> DSH payments are federal Medicaid payments intended to cover the extra costs incurred by hospitals serving a large number of low-income and uninsured patients. Unlike other Medicaid payments, federal DSH funds are capped at a state's annual allotted amount. DSH allotments vary across states and totaled about \$11.6 billion in FY 2014.<sup>119</sup> Anticipating fewer uninsured and lower levels of uncompensated care, the ACA reduces federal Medicaid DSH payments. Cuts were originally scheduled to begin in 2014 but were delayed to FY 2018. These reductions will amount to \$43 billion between 2018 and 2025.<sup>120</sup> The Secretary of HHS is required to develop a methodology to allocate the reductions that must take into account factors outlined in the law.<sup>121</sup> Providers in states that do not expand Medicaid may be particularly strained by DSH cuts, as coverage gains among low-income residents in those states are small and less likely to bring new revenue to offset DSH reductions.

**Being uninsured leaves individuals at an increased risk of financial strain due to medical bills.**

Uninsured people are more likely (36%) than those with employer sponsored insurance (12%) or those with Medicaid (17%) to report having trouble paying medical bills in the past year (Figure 11). Medical bills may also lead to serious financial strain. In 2014, 31% of uninsured adults reported that medical bills caused them to use up all or most of their savings, have difficulties paying for basic necessities, borrow money, or be contacted by a collection agency. In contrast, only 8% of those with employer coverage and 13% of those with Medicaid experienced this type of financial strain due to medical bills.<sup>122</sup>



**Most uninsured people have few, if any, savings and assets they can easily use to pay health care costs.** The average uninsured household has no net assets,<sup>123</sup> and half of uninsured families living below 200% of poverty have no savings.<sup>124</sup> Two-thirds of the uninsured say they are not confident that they can pay for the usual health care services they think they need, compared to 12% of those with employer sponsored coverage and 33% with Medicaid (Figure 11).<sup>125</sup>

**Uninsured people are at risk of medical debt.** Like any bill, when medical bills are not paid or are paid off too slowly, they are turned over to a collection agency. In 2014, nearly a third (32%) of uninsured adults said they were carrying medical debt compared to 20% of those with employer sponsored insurance.<sup>126</sup> Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States,<sup>127</sup> and uninsured people are at higher risk of falling into medical bankruptcy than people with insurance.<sup>128</sup>

## Conclusion

The ACA led to historic drops in the uninsured rate, with millions of previously uninsured Americans now insured and gaining access to health services and protection from catastrophic health costs. Historically, the options for the uninsured population were limited in the individual market, which was often expensive and under which many were denied coverage. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes below 400% of poverty in the Marketplaces.

Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage. Approximately half of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they do not meet immigration rules, or their income makes them ineligible for financial assistance. The remainder are eligible for assistance under the law but may still struggle with affordability and knowledge of options and require targeted outreach to help them gain coverage. For both eligible and ineligible remaining uninsured people, health care needs persist regardless of insurance status, underscoring the importance of safety net providers and community health clinics to serve this population.<sup>129</sup>

The ACA has provided coverage to millions of people in the United States in its first two years and has the potential to reach many more, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

# Endnotes

- <sup>1</sup> As of 2014, the ACA expands Medicaid eligibility to people under age 65 who have incomes at or below 138% of the federal poverty level. The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority to enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. For more information, see: MaryBeth Musumeci, *Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision* (Washington, DC: Kaiser Family Foundation, August 2012), <http://www.kff.org/health-reform/issue-brief/implementing-the-acas-medicaid-related-health-reform/>.
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- <sup>3</sup> Kaiser Family Foundation and Health Research & Educational Trust, *2013 Kaiser/HRET Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation and Health Research & Educational Trust, 2013), <http://www.kff.org/private-insurance/report/2013-employer-health-benefits/>.
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- <sup>7</sup> Ibid.
- <sup>8</sup> Ibid.
- <sup>9</sup> John Holohan and Megan McGrath, *Reversing the Trend? Understanding the Recent Increase in Health Insurance Coverage among the Nonelderly Population* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured and The Urban Institute, March 2013), <http://kff.org/uninsured/issue-brief/reversing-the-trend-understanding-the-recent-increase-in-health-insurance-coverage-among-the-nonelderly-population/>.
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- <sup>11</sup> Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.
- <sup>12</sup> Kaiser Family Foundation State Health Facts. Data Source: Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners and California's Department of Managed Health Care, accessed October 8, 2015, <http://kff.org/other/state-indicator/individual-premiums/>.
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- <sup>14</sup> Ibid.
- <sup>15</sup> Kaiser Family Foundation State Health Facts. Data Source: The Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplements), accessed October 8, 2015, <http://kff.org/other/state-indicator/nonelderly-0-64/>.
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- <sup>17</sup> Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.
- <sup>18</sup> Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.
- <sup>19</sup> Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.
- <sup>20</sup> "Poverty," U.S. Census Bureau, Social, Economic, and Housing Statistics Division, <https://www.census.gov/hhes/www/poverty/data/threshld/>.
- <sup>21</sup> Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.
- <sup>22</sup> Kaiser Commission on Medicaid and the Uninsured, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2013), <http://kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/>.
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<sup>29</sup> Kaiser Family Foundation analysis of the 2014 Kaiser Survey of Low-Income Americans and the ACA, 2015.

<sup>30</sup> Rachel Garfield and Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2015), <http://kff.org/health-reform/issue-brief/how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults/>.

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<sup>34</sup> Kaiser Family Foundation State Health Facts, accessed October 8, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

<sup>35</sup> Brooks et al., *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015*.

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<sup>37</sup> Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels and 2015 CPS data.

<sup>38</sup> Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

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<sup>63</sup> Kaiser Family Foundation and Health Research and Educational Trust, 2013.

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<sup>65</sup> Kaiser Family Foundation and Health Research & Educational Trust. 2015.

<sup>66</sup> Kaiser Family Foundation analysis of the 2014 Kaiser Survey of Low-Income Americans and the ACA, 2015.

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<sup>68</sup> Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> See Supplemental Tables, Table 9.

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<sup>73</sup> Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

<sup>74</sup> Kaiser Family Foundation, State Health Facts. Data Source: Based on state-reported eligibility levels as of January 1, 2015, collected through a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, accessed October 8, 2015, <http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/>.

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